Request for Additional
Level of Care Determination

Provider: _____ Date: _____

Recipient:_____

Please consider the attached application on behalf of the aforementioned recipient. This information is being submitted for level of care determination because (check one):

☐ Information previously submitted was incorrect or inaccurate.

☐ Recipient's health status and subsequent medical condition has significantly changed.

The recipient has been advised that should this additional level of care determination be denied, normal appeal rights will be provided. However, any appeal of this determination will be consolidated with the previous level of care determination that is currently in the appeal process.

Submitted by: _____
Signature

_____
Printed name